Statement of H. Sally Smith
Chairperson
National Indian Health Board
On the
Reauthorization of the Indian Health Care Improvement Act

March 8, 2000

Good Morning, Chairman Ben Nighthorse Campbell, Vice-Chairman Daniel Inouye, and distinguished members of the United States Senate Committee on Indian Affairs. I am H. Sally Smith, Chair of National Indian Health Board (NIHB). I also have the honor of serving as Chair of the Alaska Native Health Board, Chair for the Bristol Bay Area Health Consortium and Treasurer for the Alaska Native Health Consortium. Locally, I serve as the Member Chief Secretary and Tribal Judge of the Native Village of Dillingham. Nationally, I also serve on the Tribal Self-Governance Advisory Committee, on the Tribal Leaders Diabetes Committee and on the National Steering Committee on Reauthorization of the Indian Health Care Improvement Act (P.L. 94-437).

I am pleased to be here today to testify on pending reauthorization of Public Law 94-437, the Indian Health Care Improvement Act (IHCIA).

The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Areas of the Indian Health Service (IHS) and are generally elected at large by their respective Tribal Governmental Officials within their regional area. We have the duty to ensure that the solemn treaty commitments made to our ancestors are upheld in all matters related to health and human services.

Trust Obligation of the United States

The federal responsibility to provide health services to American Indians and Alaska Natives has grown out of the unique relationship between Tribal Governments and the United States. This government to government relationship arises from Article 1, section 8, clause 3 of the United States Constitution, which gives specific authority for federal supervision of Indians. Over the course of 200 hundred years, the unique federal/tribal relationship has been underscored by Treaties, Statutes, Executive Orders, and U.S. Supreme Court decisions.

For American Indian and Alaska Native people, the federal responsibility to provide health services represents a "pre-paid" entitlement, paid for by the cession of over 400 million acres of land to the United States. In many of the treaties which were negotiated between Tribes and the U.S. government, specific provisions for basic health care, such as the services of a physician and the construction and maintenance of hospitals and schools were included. The Snyder Act of 1921, provides the broad authority for Congress to appropriate funds for the, "relief of distress and the conservation of health", among American Indian populations throughout the U.S. This permanent authority is recognized as the foundation for numerous federal programs, including Indian health care.

In 1954, the Transfer Act transferred the responsibilities for health care from the Secretary of Interior to the Secretary of Health, Education and Welfare which brought a much needed public health focus towards restoring health among American Indians and Alaska Natives.

Let me begin by stating it is the consensus of the members of our board that we have a duty to ensure that the special Trust Responsibility, acknowledged and adhered to by the federal government in its relationship with the tribal nations, continues. It is an obligation of the United States Government to make certain that comprehensive health care is provided all American Indian and Alaska Native citizens.

In 1976 when Congress enacted the Indian Health Care Improvement Act, it favorably and forever changed the face of Indian policy. The Act is one of the most comprehensive efforts by Congress to address the health needs and health status of American Indian and Alaska Native populations through a series of initiatives. Its intent was to address long-standing deficiencies in Indian health care; to increase the number of health professionals serving Indian communities; to authorize services to urban Indian populations; to rectify health facility problems; and to provide access for Indian patients to other federal health resources such as Medicaid and Medicare. The IHCIA provided comprehensive directives to the federal government with regard to Indian health, and with the Snyder Act provided overall guidance and authority for the programs of the IHS.

Since its enactment 24 years ago, IHCIA has been amended numerous times and reauthorized four different times by Congress. Although improvements to the health status of American Indians and Alaska Natives have been accomplished, Indian health continues to lag behind all other groups in the United States. In addition, federal appropriations for Indian health have been shrinking relative to inflation, making it more difficult to provide health care to American Indians/Alaska Natives (Al/AN), including IHS, Tribes and urban Indian health organizations. Other trends, such as managed care and its relationship to Medicare and Medicaid programs, have strained budgets for these health programs even further.

Development of Tribal Proposal

As we are all aware, at the end of Fiscal Year 2000, the IHCIA is scheduled to expire. Over this past year the Indian Health Service, (IHS) sponsored a major consultation and drafting effort to bring together tribes, IHS and urban providers to make recommendations in drafting a proposed bill for reauthorization. This was accomplished by the IHS convening a National Steering Committee (NSC) with representatives from Tribes and national Indian organizations.

Over the course of five months, the NSC drafted specific proposed legislation, which was based upon the consensus recommendations developed at four regional consultation meetings held earlier in the year. A copy of the first draft was mailed to every tribe and every urban program on July 16th of last year, soliciting written comments. More than a thousand written comments were returned to the National Steering Committee and carefully considered as the final proposal was drafted. The final bill language was reviewed by the Steering Committee on October 5, 1999 during the National Congress of American Indians Convention in Palm Springs, and was adopted by consensus. NIHB was involved from the very beginning with the National Steering Committee and strongly endorses

the final draft reauthorizing the Indian Health Care Improvement Act. Suffice to say, P.L. 94-437 and its subsequent amendments was undoubtedly one of the most important laws affecting the health of American Indians and Alaska Natives. I hope we will continue to build on that progress by finding new ways to improve the health of our tribal populations.

Summary of the draft bill:

Title I - Indian Health Manpower:

Purpose: To increase the number of Indians entering the health professions.

Proposed Change: Use of generic terminology to include all health professions rather than a specific discipline.

Comment: In the early 1970's there were very few identifiable AI/AN health professionals. For example, in 1972 there were 75 AI/AN medical doctors but today, that number has more than quadrupled because of the Indian Health Care Improvement Act. Over 90 percent of all AI/AN health professionals who graduated under scholarship programs authorized by the IHCIA are serving villages in Alaska, on reservations in the lower 48 or addressing the needs of tribal populations in urban areas.

Proportionately, we still have fewer AI/AN health professionals than our population demands. Also, despite our advancement in recruitment, retention and placement a new dimension has been added to the equation, one which came about because of the increased number of AI/AN health professionals working with our tribal populations. As our knowledge broadened, we became increasingly aware of disease patterns revealing variations that were influenced by socioeconomic status, tribal genetics and culture. Unless we can continue to build a cadre of health professionals who can utilize the health sciences to understand the differing incidence of disease, the affects of these diseases, and tribal response to treatment, the gap limiting the health status of our tribal populations will continue to widen, further lowering the quality of life for AI/AN's.

Title II - Health Services:

Purpose: To expend funds which are appropriated to eliminate health deficiencies and resources in all Indian tribes.

Proposed Change: Reflects the increased assumption by Tribes of health programs and the changes in health care delivery since the last reauthorization and moves Section 209 Mental Health Services to Title VI I, Behavioral Health.

Comment: Far too many of our tribal members continue to die before the age of 40. Diabetes, heart disease, cancer, high cholesterol, chronic liver disease, severe obesity, smoking and inactivity are all health problems AI/ANs suffer more from than the general population. These health problems were not part of our way of life generations ago. Today, across Indian Country, there is a continuing effort to blend Western knowledge with traditional knowledge,

thereby providing a delivery of health services acquired through knowledge gained from the best of both worlds.

Since the enactment of P.L. 94-437 the health status of AI/AN's has improved through a concentrated effort by federal agencies and tribal governments to address issues related to the delivery of health services. With the inclusion of language added to many sections of this Title requiring consultation, tribes and tribal organizations are assured of their ability to carry out a broad range of health programs. However, we have yet to reach a level equal to that of the general population. We cannot rest until our tribal elders, many of whom were forcibly removed as children and placed in off-reservation boarding schools, are assured of access to long-term care within their homelands. Not until we can provide home and community based services to our terminally ill tribal members, can we rest. And, not until we can exercise our right of self-determination to effectively eliminate backlogs in health care services to all American Indians and Alaska Natives can we rest.

Title III - Health Facilities:

Purpose: To provide construction and renovation of health facilities.

Proposed Change: Provide a comprehensive view of unmet facilities needs to President and Congress for development of funding opportunities to meet needs.

Comments: The IHS implements construction projects under the authority of the Snyder Act of 1921. Over the years annual appropriations from Congress for facilities construction has varied. For example, it has fluctuated from $32 million in FY 1984, dropping to only $14 million in FY 1989, and up as high as $134 million in FY 1993. In 1994, the IHS conducted a thorough assessment of facility replacements and modernization for purposes of bringing all facilities up to levels competitive with the private sector. In the 1994 analysis, the estimated total need was $3.2 billion. Unfortunately, at the pace Congress appropriates new construction funding it will take over 70 years before all the projects on the current priority list are constructed. The NIHB supports changes to this Title that will help eliminate barriers and create innovative opportunities for construction of new and replacement health care facilities in Indian Country.

Title IV - Access:

Purpose: To address treatment of payments from third party collections.

Proposed Change: Most references to facilities replaced with programs to allow for reimbursements outside of a facility.

Comment: Many of Indian people do not have access to health care. We are well aware that the per capita expenditure for an Indian person was $1,430 as compared to $3,369 for a Medicaid beneficiary and $5,458 for a Veterans' Administration beneficiary. As you can well observe, Indian people in the Indian Health Service programs are not being served under the Nation's first prepaid

health plan at a level which even meets one-third of what is available to a Medicaid and one-fifth of what is available to Veterans' Administration beneficiaries. Even though many Indian people are eligible to participate in Medicaid and Medicare, there are many barriers which limit their participation. Tribal and IHS health programs do not have equal access to these programs due to technical legislative impediments. At the same time, new Medicaid managed care efforts are largely controlled by State governments and managed care providers who will do their best to count Indian patients as a part of their plan, but will not make reasonable reimbursements to Indian health programs. And while improvements have been made to increase reimbursement rates within Indian health programs, the net gains in collections simply do not equal the disparity inherent in the IHS Budget.

Even when Indian people secure care in IHS or tribal programs, they may not have access to a full range of health care services that insured people or non-IHS clients enjoy. Senators, as you are aware being an AI/AN does not mean one enjoys full health coverage, as many Americans tend to think. IHS clinics are typically wrought with long waiting times, crowded clinic conditions, and minimal time to see the provider. Many IHS facilities do not have the technology enjoyed by others. The IHS system remains underfunded, even though there continues to be severe health status deficiencies among our tribal populations. The NIHB supports removing limitations on the IHS, Tribes and tribal organizations to bill Medicare, Medicaid and Child Health Insurance Programs so that Indian health programs can take maximum advantage of this funding stream.

Title V - Health Services for Urban Indians:

Purpose: To establish accessible health services to urban Indians.

Proposed Change: Provides urban Indian programs with protections and access comparable to those available to other Indian health programs without compromising tribal sovereignty.

Comment: For the record, I believe it is important to reiterate the moral and legal responsibilities to AI/ANs, in which the U.S. government appropriates funds for the Indian health care system complementing a partnership of federal, tribal, and urban Indian operated health care programs. Despite these moral and legal principles, AI/AN's have long experienced health problems disproportionately compared with other Americans. Whether they are reservation or urban, their life expectancy is less than other Americans, they die at higher rates than other Americans and their lingering health disparities are shocking. It is no wonder that when provided an opportunity to recover their position of self-sufficiency they migrated to America's cities with the hope for a better quality of life.

The migration which began after World War 11 was promoted by the Bureau of Indian Affairs which advocated the "Relocation Program" to tribal populations. It is estimated that over 160,000 of our tribal members were relocated to urban areas between 1950 and 1960. In light of our strong tribal kinship systems, we must never forget the hardship our family members suffered as they found themselves in cities where little support, if at all, was provided them. Although life on the reservation

and in the villages was also difficult, we continued to be closely related socially and culturally as families, within our respective tribal units. None of that has changed.

Studies on urban Indian populations reveal a serious lack of adequate health care. Under the IHCIA, Title V specifically authorizes health outreach and referral and the delivery of services to Indian people in urban areas. The NIHB supports the draft language within Title V, which represents a wide array of health care opportunities for urban Indian centers. These include requiring the Department of Health and Human Services to set up procedures for consultation with urban Indians on issues affecting the AI/AN people they serve and to allow for urban Indian programs to obtain malpractice coverage under the Federal Tort Claims Act.

Title VI - Organizational Improvements:

Purpose: To establish IHS as an agency of the PHS.

Proposed Change: Possible language to include the elevation of the Director of IHS.

Comment: For the last three years, the NIHB joined forces with the Tribal Self-Governance Advisory Committee and the National Council Urban Indian Health to request special legislation to elevate the Director of the Indian Health Service to Assistant Secretary for Indian Health within the Department of Health and Human Services. We appreciate passage of S. 299 and hope the House will soon take action on their companion measure. If they do not, we believe elevation should be added to the reauthorization bill.

Title VII - Behavioral Health:

Purpose: To outline responsibilities of IHS pursuant to section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986.

Proposed Change: The aim is to integrate substance abuse, mental health and social services into holistic Behavioral Health programs.

Comments: Statistics reflect the effects of cultural oppression, racism, loss of traditions, boarding schools, and its impact on family and parenting, alcoholism and substance abuse, and internal violence as major contributions to sustained, multi-generational behavioral problems in our American Indian and Alaska Native communities. The NIHB supports integrating programs which are nurturing, fulfilling, accountable, and responsible in their ability to offer significant insight and opportunity for wellness and balance in our tribal communities. Tribal communities are taking a leadership role in addressing the myriad of needs associated with behavioral health problems, therefore the ability to contract and compact will offer greater coordination of resources to achieve the goal of tribal wellness.

Title VIII - Miscellaneous:

Purpose: To address various topics.

Proposed Change: Establishment of an Entitlement Commission, and enacts provisions for negotiated rule making and various other improvements.

Major Concerns

The National Indian Health Board recognizes that the complexity associated with Indian health care, as with non-Indian systems, is significant and far reaching. Each of our Board Members have been engaged in extensive dialog within their respective Areas with Tribal Leadership, tribal health directors and health care providers. Once a Senate bill is introduced, we expect each of the respective Area Health Boards and Intertribal organizations will consider their position and will offer resolutions of endorsement and opposition later this Spring. Since nine of our Board Members were a part of the National Steering Committee responsible for drafting the bill, we will likely support the enactment dependent on the views of each Area. At this point, we want to emphasize the following points.

Maximizing Local Tribal Control

Twenty-five years ago, two important public laws changed the delivery of health care in Indian Country. The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), and the 1988 and 1994 Amendments to the Act, as well as the Indian Health Care Improvement Act of 1976, gave new opportunities and responsibilities to the Indian Tribes and tribal organizations in the management of health care services. Self-Determination and Self-Governance provided for in Title III of the ISDEAA today is having a significant impact on the way Federal health services are provided in Indian communities. The IHS reports that at least 45 percent of the budget is currently under an Indian Self-Determination contract or Self-Governance compact. In our study, *"Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management,"* we found that of the 21 0 tribes surveyed, 75 percent were already contracting some IHS program and within the next five years 94 percent planned to be under a contract or compact with the IHS. Tribes involved in this study report improved quality of care and better health systems after contracting and compacting.

The policy of Self-Determination and Self-Governance is having a profound impact on health care in Indian Country. Utilizing the insights from their experience in managing their health care services, Tribal Governments are working to ensure that new policies and the budget authority contained within the annual budget justification document is responsive to their health needs.

In order to ensure that the Indian Health Care Improvement Act is responsive to the growth of Indian Self-Determination Contracts or Self-Governance Compacts, we strongly support the policy changes contained in the Tribal proposal.

Promoting Innovation, Flexibility and Creative Financing in Facility Construction

At present the Indian Health Service does not provide Congress with information on the full health facilities needs in Indian Country although the absence of adequate health facilities is well known to be one of the primary obstacles to health services improvement. We strongly support the requirement in the bill which requires that IHS provide this information to Congress annually. In addition, we urge enactment of the innovative approaches to increase the resources available for health facility construction, renovation and expansion contained in Title III.

Need for Entitlement Designation

The bill addresses the issue of the right of American Indians and Alaska Natives to receive services provided for in the Act and in many Treaties. By establishing an Entitlement Commission including Congressional and Tribal Representatives to study the questions which need to be resolved in defining an entitlement, we expect: (1) to clarify just what types of services are included; (2) to whom does the entitlement serve (individual Indians or Tribes); and (3) how is the entitlement to be funded.

Authorization for Appropriations and Balanced Budget Act Concerns

When the Senate Committee on Indian Affairs held its briefing on the proposed amendments to the Indian Health Care Improvement Act on February 17, 2000, a question was posed about the potential cost of the entire bill. It was noted that new amendments would be subject to Appropriations caps and since the bill would still be considered as discretionary and not necessarily an entitlement measure, the pay-as-you-go rules would not be applicable. The National Indian Health Board is just anxious as the Senate Committee to review the Congressional Budget Office estimate so that we can ascertain the costs of this draft bill.

In anticipation of the cost estimate, the National Steering Committee on P.L. 94-437 requested a section-by-section analysis of the existing authorization bill which displays authorizations as compared to appropriations. It should be noted that the existing law contains 120 provisions, of which 93 would be regarded as actual authorizations for appropriations. At least 27 provisions are to be considered "not applicable" in terms of directed appropriations. Some provisions indicate a certain level of authorizations ""not more than" a certain amount or "not less than" a certain authorization amount. And many provisions authorize "such sums as are necessary". We raise this point because we want to be perfectly clear in noting that only 27 of the 93 funding authorities are indeed funded with appropriations in the existing law.

In FY 2000, the 27 provisions which are actually funded in the Indian Health Care Improvement Act amounts to $382.4 million. There are 66 provisions which constitute "unfunded mandates" in the existing law. The anticipated cost for these 66 provisions is not available, however, the establishment of these authorities in 1992 did not complicate enactment of the reauthorization bill.

It is anticipated that certain provisions contained within Title IV of the legislative proposal will have limited budgetary impact affecting Medicare, Medicaid and State Child Health Insurance Programs. However, we want to make it very clear that much of the scoring associated with these provisions is already counted for within the existing entitlement spending authorized for under these Social Security Act programs. The provisions we seek merely enhance the access potential for American Indians and Alaska Natives who qualify for these programs and are counted for within the current offsets contained in these Social Security Act programs. The benefits they provide are consistent with those given to other special providers and recognize the unique relations between the United States and Tribes. The costs for implementing the Title IV programs are insignificant in the overall budget for Medicare and Medicaid and in many cases are already present in the program. We look forward to studying the CBO estimate to consider the cost implications of these amendments.

Interim Extension to Maintain Authorization

We are very aware that this year is a Presidential election year and it is understood that very few authorization bills will be able to successfully weave their way thru the legislative process. Tribal Governments are still optimistic that the proposal sent forth by the National Steering Committee on P.L. 94-437 will be enacted within the 106th Congress. And yet it is understood that the comprehensive aspects of this legislative proposal may require extensive discussion by the Committee's Members. Once the bill is introduced, we respectfully recommend that a reasonable time frame for hearing consideration be specified within the Sponsor's Introductory Statement so that Tribal Governments can plan for potential field hearings if requested by Members of the Committee. We believe it is reasonable to limit the number of hearings since the draft bill was the subject of extensive discussion by Tribal Governments during the ten months of its development.

In the event that enactment of this bill is not possible, we recommend that the Committee send forward a request to the Interior Appropriations Subcommittee requesting that the Indian Health Care Improvement Act be extended for a period of one year beginning October 1, 2000. This extension will ensure that existing authorizations for appropriations are continued while the bill is under consideration.

Request for Field Hearing

In the event that the Senate bill is not reported out of the Committee by August 21, 2000, the National Indian Health Board respectfully requests that a field hearing be held during our Annual Consumer Conference this summer. The 18th Annual Consumer Conference will be held in Billings, Montana, during the week of August 20 to 25th , 2000. The eight tribes who comprise the Montana Wyoming Area Indian Health Board will be serving as our hosts this year and would be certainly welcome the Senate Committee on Indian Affairs to this event.

Conclusion

On behalf of the National Indian Health Board, we thank the Senate Indian Affairs Committee for hosting today's hearing on the Indian Health Care Reauthorization proposal.

As Chairperson of the NIHB, I pledge our organization will help educate the Senate Finance Committee, House Resources Committee, House Commerce Committee, House Ways and Means, and House Government Reform Committee on how important reauthorization is to the health needs of American Indians and Alaska Natives.

I call upon my Indian friends to work together with the distinguished Chairman of the Senate Committee to uphold the Treaty commitments of our ancestors to ensure that our health care fully meets our needs. Indian health care is a right and reauthorization is vital to the health of our people. Thank you!